Needham Chiropractic Assoc., P.C.

1410 Highland Avenue Needham, MA 02492
2nd floor Suite 201

From 128 South –

Take Exit 19B Highland Ave – toward Needham

Go thru 5 traffic lights, at fifth light you will see Needham Service Station on your right. St. Joseph's school will be on your left.

We are located in the brick building between St. Josephs School and Babel's paint.

Parking is located behind the building. – 2nd floor – Suite 201

From 128 North–

Take Exit 17 toward Needham – At end of ramp take right.

At 3rd Traffic light you will see Sovereign Bank. Go thru light keeping bank on your right.

Approx. 1/8 mile you will pass Wallgreens on your right. At this point start to look for Fuji Steak House and Babel's paint, also on your right.

Take immediate right into the driveway after Babel's paint.

We are the brick building located next to Babel's paint – 2nd floor Suite 201.

If you see St. Joesph's school on your right, you have gone too far.

WE'D LIKE TO GET TO KNOW YOU BETTER!

Name:_____Birthdate:_____

Address:_____City/St._____Zip_____

Home Phone:_____Cell:_____Work:_____

Email:_____
Single:_____ Married_____ Divorced_____ Widowed _____ Separated_____

Occupation:_____Employer:_____

Primary Care Doctor:_____

Who shall we call in case of emergency?_____
Their phone number:_____

Who referred you to our office?_____

Have you undergone chiropractic care before?_____
When_____Where_____

PRIVACY NOTICE ACKNOWLEDGEMENT:
We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA) we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully for it outlines the use and limitations of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

I waive my right to privacy regarding the daily sign-in sheet for purposes of proof of attendance.

I acknowledge that I have been offered a copy of NEEDHAM CHIROPRACTIC ASSOCIATES' "Notice of Privacy Practices for Protected Health Information".

_____ _____
Patient Signature Date

_____ _____
Personal Representative Signature Authorized Provider Rep. Signature

HEALTH HISTORY

Please Print Name:_____
Date*:*_____

1. My health goals are:
   - ____correction/stabilization
   - ____health maintenance
   - ____pain relief

2. Please check area(s) of complaint:

____low back pain	_____neck pain
____hip/buttock pain. __R__L	_____shoulder pain. __R __L
____leg pain. __R __L	____arm ____hand pain. __R __L
____foot pain __R __L	____mid-back pain.
____other_____ (Specify)	____headache.

3. When did the pain begin? Approximate date:_____
   - ____gradually, without incident.
   - ____with specific incident.

4. Explain the accident/injury or how you think it occurred: _____

_____

5. What makes the symptoms worse?

____sitting	____looking down
____getting out of a chair	____sneezing
____getting out of bed	____coughing
____turning in bed	____having a bowel movement
____backing up the car	____other- please specify: _____

6. How does the pain feel?

____sharp	____burning	____other – please specify:
____dull	____numbness	_____
____throbbing	____tingling	_____
____cramping	____weak or lame	

7. Does the pain or symptom travel from one site to another?
   ____No ____Yes Explain:_____
_____

8. How much does it hurt? **0 1 2 3 4 5 6 7 8 9 10** (0=no pain 10=severe and incapacitating pain)

9. Does your pain change with activity? ____No____Yes
Explain:_____
_____

PLEASE CHECK THE FOLLOWING:

1. Have you ever had cancer? ____Yes ____No
2. Does your pain ever awaken you from a sound sleep? ____Yes ____No
3. Are you losing weight now, without trying? ____Yes ____No
4. Are you coughing up blood or noticing it in your stools or urine? ____Yes ____No
5. Have you had any loss of bladder or bowel control? ____Yes ____No
6. Have you lost consciousness or had double vision recently? ___Yes ____No
7. Do you have a pace maker? ____Yes ____No
8. Are you seeing any other doctor now for any reason? ____Yes ____No
   Specify:_____
9. Do you have any other symptoms or health problems? ____Yes ____No
   Specify:_____
10. Are you taking any medications or over the counter drugs now, (i.e. anti-coagulants)?
    ____Yes ____No List them:_____
11. Do you have any food or drug allergies (i.e. shellfish)? ____Yes ____No
    List them:_____

PAST TREATMENT HISTORY:

_____
_____
_____
_____
_____
_____

NEEDHAM CHIROPRACTIC ASSOCIATES
Patient Informed Consent

All health care professionals (anesthesiologists, chiropractors, dentists, medical doctors, osteopathic, pharmacists, surgeons, etc.) are regulated by laws and boards. These health care professionals are required to give you, the patient, advance notice of any risks, and/or complications. Informed consent information regarding any risks does not necessarily indicate an error in clinical judgment. No guarantee of cure or results has been made to you, the patient, in this clinic. Your care may involve the making of recommendations based upon facts known to the doctor at this time. Chiropractic care does not use drugs or surgery and does not diagnose internal and/or medical conditions.

You should understand the benefits of chiropractic health care, but you also need to be aware of some of the limited, inherent risks. These seldom occur; not enough to contraindicate care, but should be considered in your informed decision to receive chiropractic care.

All health care procedures have some risks. With chiropractic adjustments the risk may include musculoskeletal sprain/strain, disc injuries, dislocations, fractures, neurological deficits, Horner's Syndrome, Vertebral Artery Syndrome, or stroke. The chances of these risks occurring have been estimated by experts to be approximately 1 per 400,000 treatments, to 1 per 1,000,000 treatments.

Appropriate tests will be performed to identify if you may be susceptible to these risks and you will be notified in that case. If you have any questions about these issues, please do not hesitate to speak with your doctor of chiropractic.

I have read (or have had read to me) the above information. I wish to rely on the doctor's judgment during my course of care, based upon the facts then known. I have also had the opportunity to ask questions regarding the above information and possible consequences and risks. By signing below, I now agree to have the chiropractic care procedures recommended and performed. I have no questions and I acknowledge that no guarantee of cure has been made to me concerning results and treatment.

Patient Name (printed)	**Patient Signature**	**Date**
Patient/Guardian Signature (if minor)	**Staff/Witness Signature**	**Date**

FINANCIAL AND APPOINTMENT POLICIES

PAYMENT IS DUE AS SERVICES ARE RENDERED

We gladly accept Cash, Checks, Visa and MasterCard.

INSURANCE: Health care policies of insurance companies with whom this office participates will be verified. Verification is not a guarantee of coverage or payment. We will accept assignment as specified for your particular plan. **Patients are responsible for all deductible amounts, co-payments and non-covered services. It is the patient's responsibility to keep track of how many visits are allowed and used on their insurance.** For all other insurance companies patients are required to pay at the time of service.

MISSED APPOINTMENTS: Please try to notify our office as soon as possible of an appointment change so that we can accommodate your needs as well as the needs of other patients. Patients may be charged a missed appointment fee of $45.00 without same day notice prior to a scheduled visit. This charge is a patient's responsibility and cannot be billed to insurance.

I understand and agree that all fees for professional services rendered on my behalf are my personal responsibility, due and payable at the time services are rendered. If you have a flex spending or employer contribution account, we will provide you with receipt for reimbursement. Payment is due at the time of service.

_____ _____

Patient Signature **Date**

ASSIGNMENT OF BENEFITS:

I hereby authorize and direct Needham Chiropractic Associates, P.C. to release medical information necessary to process my insurance claims. I also authorize and direct my insurance carrier to pay all benefits, which may be due to me according to my policy, to Needham Chiropractic Associates, P.C.

_____ _____

Patient Signature **Date**